MONTANA BOARD OF MEDICAL EXAMINERS

P. O. Box 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
(406) 841-2361 or (406) 841-2364 FAX (406) 841-2305
E-MAIL dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

APPLICATION PROCEDURES FOR MONTANA TELEMEDICINE CERTIFICATE

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 10 days for processing from the date that the Board has a complete routine application)

PHYSICIANS ARE NOT PERMITTED TO PRACTICE MEDICINE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE OR TELEMEDICINE CERTIFICATE

LICENSING REQUIREMENTS:

- Current active, unrestricted physician license in another U.S. State or territory
- Board-Certified **OR** meets the current requirements to take the examination to become Board-certified in a medical specialty pursuant to the standards of, and approved by the American Board of Medical Specialties ort the American Osteopathic Association-Bureau of Osteopathic Specialists
- An identified agent for service of process in Montana, who is registered with the Montana Secretary of State and the board and who may be a physician certified practice medicine in this state
- Proof of current malpractice insurance or professional negligence insurance coverage in the amount of $1,000,0000
- Proof that the applicant has established or regularly used connection with the State of Montana including but not limited to a least one of the following:
    - An office or other place for the reception of a transmission from the applicant, located in Montana
      OR
    - Contractual relationship with a person or entity in Montana related to the applicant's practice of Medicine
      OR
    - Privileges in a Montana Hospital or another Montana Healthcare facility as defined by MCA 50-5-101
- No history of disciplinary action or limitation of any kind imposed by a state or federal agency in a jurisdiction where the applicant is or has ever been license to practice medicine
- The applicant must not be subject to a pending investigation by a state medical board or by another state or federal agency
- The applicant has no history of conviction of a crime related to the physician's practice of medicine
- Applicant must not have paid or had paid on the applicant's behalf, on more than three claims of professional malpractice or negligence within the 5 years preceding this application for a telemedicine certificate

FEES: **$300.00** (Non-refundable) *Make payable to: Montana Board of Medical Examiners

DOCUMENTS: The following documentation must be submitted in order to complete your license application.

- **Proof of Malpractice or Professional Negligence Insurance**
- **List of Agent(s) of Service**
- **Current verification from all State Licensing Boards**

APPLICATION PROCEDURES:

- When the application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified it additional information is required or if required to appear before the Board for an interview.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or a make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-Routine applications may take up 120 days to process.
- All verifications of licensure must be sent to directly from all state boards, to the Montana Board, in which the applicant holds or ever held a license to practice medicine. Please make copies of the attached verification request form as needed. Some states will charge a fee for verifications. Contact each state prior to sending the request.

PROCESSING PROCEDURES:

- Once a routine application is complete, the application takes up to 10 days to process from the time it is received in the Board office.
- The applicant will be notified in writing of any deficient or missing items from the application file.
- Once a routine application is processed and approved a permanent license will be issued.

For information with regard to the processing of this application or other concerns please contact the Board of Medical Examiners staff at (406) 841-2361- or (406) 841-2364 e-mail us at dlibsdmed@.mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICINE ON OUR WEBSITE: www.medicalboard.mt.gov

MONTANA BOARD OF MEDICAL EXAMINERS
301 S Park Avenue, 4th Floor
PO Box 200513
Helena MT 59620-0513
Phone: 406-841-2361 FAX 406 841-2305
E-MAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

Initial Application for Telemedicine Certification as:

☐ **M.D.** ☐ **D.O.**

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 10 days for processing from the date that the Board has a complete routine application)

PLEASE TYPE OR PRINT

1. FULL NAME: _____
   Last First Middle
2. OTHER NAME(S) KNOWN BY _____
3. BUSINESS NAME _____
4. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip
5. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS _____
6. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE
   City/State
9. LICENSE NAME _____
   (State your name as it should appear on the license if granted.)
10. List all state(s) in which you hold or ever held a license to practice medicine: (If more, please indicate on attached sheet)

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No

11. In accordance with 37-3-345(2), MCA, the following is requested:

A. Are you board-certified? If yes, please indicate below: ☐ Yes ☐ No

SPECIALTY	NAME OF CERTIFYING BOARD

OR

B. Do you meet the current requirements to take the examination to become board-certified in a medical specialty pursuant to the standards of, and approved by the American Board of Medical Specialties or the American Osteopathic Association-Bureau of Osteopathic Specialists? If yes, please submit verification from certifying Board. ☐ Yes ☐ No

12. Please identify all Agents for service of process in Montana in accordance with 37-3-345(8) MCA.

CORPORATION OR BUSINESS NAME	COMPLETE ADDRESS	TELEPHONE #	MEDICAL LICENSE #	REGISTERED WITH SECRETARY OF STATE
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

13. Please verify your Malpractice Insurance coverage by submitting an original "Certificate of Insurance" or a complete copy of your policy.

Name of Insured	Name of Insurance Carrier	Policy #	Coverage Period	$ Amount

14. In accordance with 37-3-342(1)(c), MCA, the applicant must establish or regularly use a connection with the State of Montana including but not limited to at least one of the following:

a. Please provide the Board with the name, address, and telephone of an office or other place for the reception of a transmission to the applicant, located in Montana.

NAME	ADDRESS	TELEPHONE#

OR

b. Please provide proof of a contractual relationship with a person or entity in Montana related to the applicant's practice of medicine.

OR

c. Please provide proof of privileges in a Montana hospital or another Montana Healthcare facility, as defined in 50-5-101, MCA.

15. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements. ☐ Yes ☐ No

16. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

17. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No

18. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

19. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No

20. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation. ☐ Yes ☐ No

21. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No

22. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines and (2) charges or convictions prior to your 16th birthday. If yes, please attach a detailed explanation. ☐ Yes ☐ No

23. Do you have any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No

24. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Department of Labor and Industry, Healthcare Licensing Bureau.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Legal Signature of Applicant Date

Subscribed and sworn to before me this _____ day of _____, _____at

_____.
City/State

_____
Signature of Notary Public

_____
Printed Name of Notary Public

SEAL

_____
For the State of

My commission expires _____, _____.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE MEDICINE OR TELEMEDICINE. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a certificate to practice telemedicine in the State of Montana. The Montana Board of Medical Examiners requires this form to be completed by each state wherein I hold or ever have held a professional or occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

NAME	COMPLETE ADDRESS	LICENSE #	SOCIAL SECURITY #

_____ _____

SIGNATURE **DATE**

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of:_____

Full Name of Licensee:_____

License No._____Issue Date:_____ Expiration Date_____

Licensed by:

- ☐ National Boards (score) _____ (Year) _____
- ☐ FLEX (score) _____ (Year) _____
- ☐ USMLE (score) _____ (Year) _____
- ☐ Reciprocity (score) _____ (Year) _____
- ☐ State Exam (score) _____ (Year) _____
- ☐ Other Method (Explain) _____(score) _____ (Year) _____

Has disciplinary action ever been taken against this license? ☐ Yes ☐ No

If YES, explain and attach documentation._____

Has licensee ever been requested to appear before your Board? ☐ Yes ☐ No

If YES, explain_____

Signed:_____

Title:_____

BOARD SEAL

State Board:_____

Date:_____